Section 5420.Exhibit D Application for Registration of a Utilization Review Organization

1. Name of Applicant _____

Type of Applicant (check one):

___ Corporation
___ Partnership
___ Limited Liability Corporation
___ Other (Describe) _____

FEI Number _____

Contact Person_____
Business Telephone Number (__)_____
Fax Number (__)_____
Email Address _____

2. Type of Utilization Review Organization (check one):

___ Health Care Utilization
___ Comprehensive Utilization Review
___ Specialty Utilization Review

Check **all** categories that apply (as applicable):

___ Licensed HMO providing utilization review services outside of the HMO
___ Licensed HMO providing utilization review services only within that HMO
___ Third Party Administrator
___ Licensed insurance company providing utilization review services outside of that insurance company
___ Licensed Insurance Company providing utilization review services only within that insurance company
___ Hospital or medical group providing utilization review services for other than internal purposes
___ Other (Describe) _____

3. Business Address

Street (do not use PO Box) _____
City _____ State _____ Zip _____

4. Mailing Address
Street or P.O. Box _____
City _____ State _____ Zip _____

5. Business Telephone Number (___)_____
Toll Free Number (___)_____
FAX Number (___)_____
Email Address/Website _____

6. Agent for Service of Process in Illinois

Name _____
Street Address (do not use P.O. Box) _____
City _____ State _____ Zip _____

7. For each Utilization Review Program supply the following information:

a) The name, address, telephone number and normal business hours of the utilization programs.

b) The organization and governing structure of the utilization review programs.

c) The number of lives for which utilization review is conducted by each utilization program.

d) Hours of operation of each utilization review program.

e) Description of the grievance process for each utilization program.

f) Number of covered lives for which utilization review was conducted for the previous calendar year for each utilization review program.

g) Written policies and procedures for protecting confidential information according to applicable State and Federal laws for each utilization review program.

h) Biographical information for organization officers and directors as set forth in Exhibit E of this Part. Biographical affidavits shall be stamped "confidential" by the utilization review organization.

8. Indicate accreditation status below.

a) ___ Accredited by:
___ URAC
___ NCQA
___ JCAHO

b) ___ Unaccredited.

9. Affirmation (to be signed by an officer or director of the utilization review organization only):

I, _____ do hereby certify that
(typed name, title)

_____
(utilization review organization)

complies with the Health Utilization Management Standards of the American Accreditation Healthcare Commission (URAC) sufficient to achieve American Accreditation Healthcare Commission (URAC) accreditation or submits evidence of accreditation by the American Accreditation Healthcare Commission (URAC) for its Health Utilization Management Standards, and do hereby affirm that all of the information presented in this application is true and correct.

_____ _____
(signature) (date)

(Source: New Section added at 24 Ill. Reg. 9429, effective July 1, 2000)